National Institute for Health and Clinical Excellence

Consultation on potential new indicators for the 2013/14 Quality and Outcomes Framework (QOF)

Consultation dates: 9 January 2012 – 6 February 2012

This document outlines the 20 indicators currently being consulted on including a brief rationale and topic overview for each indicator (appendix A) and the consultee comments proforma (appendix B).

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Indicators for consultation

There are 20 potential new QOF indicators across nine areas that are currently being consulted on in this document.

Indicator disease domain	Number	Indicator
COPD	1	The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the preceding 15 months
COPD	2	The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of a referral to a pulmonary rehabilitation programme (excluding patients on the palliative care register)
Heart Failure	3	The percentage of patients with heart failure (diagnosed after 1/4/2013) with a record of referral for an exercise based rehabilitation programme
Secondary prevention of CHD	4	The percentage of patients with an MI within the preceding 15 months with a record of a referral to a cardiac rehabilitation programme
Diabetes	5	The percentage of male patients with diabetes with a record of being asked about erectile dysfunction in the preceding 15 months
Diabetes	6	The percentage of male patients with diabetes who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 15 months
Depression	7	The percentage of patients with depression who have had a bio-psychosocial assessment by the point of diagnosis
Depression	8	The percentage of patients with a new diagnosis of depression (in the preceding 1 April to 31 March) who have been reviewed within 10-35 days of the date of diagnosis
Diabetes: Lipid management	9	The percentage of patients with Type 2 diabetes aged 40 years and over with successful lipid management defined as either: 1. last recorded cholesterol in the preceding 12 months ≤ 4.0mmol/l 2. last recorded cholesterol in the preceding 12 months > 4.0mmol/l and commenced on a moderate dose generic statin within 90 days of cholesterol recording 3. last recorded cholesterol in the preceding 12 months > 4.0mmol/l and generic statin dose increased within 90 days of cholesterol recording 4. or, last recorded cholesterol in the preceding 12 months > 4.0mmol/l and cholesterol lowering therapy changed to a different drug within 90 days of cholesterol recording

Hypertension	10	The percentage of patients under 80 years old with hypertension in whom the last recorded blood pressure (measured in the preceding 9 months) is 140/90 or less
Hypertension	11	The percentage of patients aged 80 years and over with hypertension in whom the last recorded blood pressure (measured in the preceding 9 months) is 150/90 or less
Rheumatoid arthritis	12	The practice can produce a register of all patients aged 16 years and over with rheumatoid arthritis
Rheumatoid arthritis	13	The percentage of patients with rheumatoid arthritis in whom CRP or ESR has been recorded at least once in the preceding 15 months
Rheumatoid arthritis	14	The percentage of patients with rheumatoid arthritis aged 30-84 years who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 15 months
Rheumatoid arthritis	15	The percentage of patients with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA
Rheumatoid arthritis	16	The percentage of patients with rheumatoid arthritis who have had a face to face annual review in the preceding 15 months
Asthma	17	The percentage of patients, 5 years and over, newly diagnosed as having asthma from 1 April 2013 in whom there is a record that the diagnosis of asthma has been made supported by the current BTS-SIGN guidelines
Asthma	18	The percentage of children reaching the age of 5 years after or on 1 April 2013 with an existing diagnosis of asthma in whom there is a record that the diagnosis of asthma has been reviewed and confirmed (supported by the current BTS-SIGN guidelines) within 15 months of becoming 5 years
Cancer	19	The percentage of patients with cancer diagnosed within the preceding 18 months who have a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis
Cancer	20	The percentage of patients with recurrent or distant metastatic cancer diagnosed within the preceding 18 months who have a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis

Background

As part of the indicator development process for the Quality and Outcomes Framework (QOF), stakeholders have the opportunity to comment on potential new indicators for the NICE QOF menu of indicators. We encourage stakeholders from all participating countries to comment on the 20 potential new indicators for that are now out for consultation.

The Consultation dates are 9th January 2012 – 6th February 2012. A brief rationale and topic overview for each indicator is provided in appendix A. The consultee comments proforma is provided in appendix B.

These indicators are not the final indicators for the NICE QOF menu of indicators. The development process includes both piloting and consultation of indicators. Indicators are subject to change following consideration of the results of piloting and consultation. Comments received during the consultation will be considered by the independent Primary Care QOF Indicator Advisory Committee in June 2012, along with the results of the piloting of these indicators across a representative sample of general practices. The Committee will then recommend which of these indicators should be considered for inclusion on the NICE menu for consideration for the 2013/14 QOF.

For some indicators it is necessary to develop different permutations of the same indicator for the piloting and consultation processes. The results of piloting and consultation will allow the QOF Advisory Committee to make a decision on the most appropriate indicator (subject to any further amendments made by the Committee) to progress for inclusion on the NICE menu for the QOF.

Negotiations between NHS Employers, on behalf of the UK Health Departments and the General Practitioners Committee on behalf of the British Medical Association, will decide which indicators are eventually adopted into the 2013/14 QOF.

Questions to consider in the consultation

Stakeholders are welcomed to submit comments based on the following set of questions:

1. Do you think there are any barriers to the implementation of the care described by any of these indicators?

2. Do you think there are potential unintended consequences to the implementation of any of these indicators?

3. Do you think there is potential for differential impact (in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation), if so please state whether this is adverse or positive and for which group?

4. If you think any of these indicators may have an adverse impact in different groups in the community, can you suggest any guidance on adaptation to the delivery of the indicator to different groups which might reduce health inequalities?

In addition to the above questions, stakeholders are invited to comment on specific questions for some of the indicators.

How to submit your comments

If you would like to comment on any of the above 20 indicators currently being consulted on please use the comments proforma provided in appendix B (also available on the NICE website) and forward this to Emma Boileau at **qof@nice.org.uk** by 6th February 2012.

Appendix A: Brief rationale and topic overview for indicators out for consultation

This section provides a brief rationale for each of the topic areas out for consultation; however the rationale is not formal indicator guidance. This will take in to account the results of public consultation and be published when the full set of indicators for the NICE menu for the 2013/14 QOF has been published.

Indicator area: Chronic obstructive pulmonary disease (COPD)

Indicators

1. The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the preceding 15 months

2. The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of a referral to a pulmonary rehabilitation programme (excluding patients on the palliative care register)

Evidence Source

Long term oxygen therapy (LTOT)

NICE clinical guideline 101: Chronic obstructive pulmonary disease (partial update of NICE clinical guideline 12)

Recommendation 1.2.5.4: The need for oxygen therapy should be assessed in:

- all patients with very severe airflow obstruction (FEV1 < 30% predicted)
- patients with cyanosis
- patients with polycythaemia
- patients with peripheral oedema
- patients with a raised jugular venous pressure
- patients with oxygen saturations ≤ 92% breathing air.

Assessment should also be considered in patients with very severe airflow obstruction (FEV1 30–49% predicted).

Recommendation 1.2.5.5: To ensure all patients eligible for LTOT are identified, pulse oximetry should be available in all healthcare settings.

NICE COPD Quality Standard

People with COPD potentially requiring long-term oxygen therapy are assessed in accordance with NICE guidance by a specialist oxygen service.

Pulmonary rehabilitation

NICE clinical guideline 101: Chronic obstructive pulmonary disease (partial update of NICE clinical guideline 12)

Recommendation 1.2.8.1: Pulmonary rehabilitation should be made available to all appropriate people with COPD (see 1.2.8.2) including those who have had a recent hospitalisation for an acute exacerbation.

Recommendation 1.2.8.2: Pulmonary rehabilitation should be offered to all patients who consider themselves functionally disabled by COPD (usually MRC grade 3 and above). Pulmonary rehabilitation is not suitable for patients who are unable to walk, have unstable angina or who have had a recent myocardial infarction.

NICE COPD Quality Standard

People with COPD meeting appropriate criteria are offered an effective, timely and accessible multidisciplinary pulmonary rehabilitation programme

Brief rationale

There is evidence that the use of long term oxygen therapy (LTOT) improves survival in people with COPD who have severe hypoxaemia (PaO2 < 8kPa), and that pulmonary rehabilitation can improve outcomes for people with COPD.

The two potential new QOF indicators for COPD therefore relate to:

a) the recording of oxygen saturation value in order to promote the identification of people who would benefit from referral to a specialist oxygen service for assessment of the need for long term oxygen therapy to.

b) referral of appropriate COPD patients to a pulmonary rehabilitation programme.

Topic overview

1. Long term oxygen therapy

The NICE clinical guideline and quality standard on COPD recommend that people with COPD potentially requiring LTOT are assessed in accordance with NICE guidance by a specialist oxygen service.

The need for oxygen therapy can be assessed using a number of factors including an assessment of oxygen saturation being less than or equal to 92% breathing air (NICE COPD clinical guideline 101) through the use of pulse oximetry. Pulse oximetry (Spo2) provides a non-invasive estimate of arterial oxygen saturation (SaO2). Pulse oximetry allows a GP to assess a patient's level of oxygen saturation and to determine if they should be referred for clinical assessment to determine if they need long term oxygen therapy. Pulse oximetry is most valuable clinically as a screening tool to identify those people who require referral for assessment for LTOT as it can reliably exclude people who are not hypoxaemic, that is, who have a SaO2 greater than 92%. What pulse oximetry cannot do is reliably predict which of those with an abnormal reading have hypoxaemia sufficiently severe to need LTOT, which is why such people need further assessment which will require arterial blood gas measurement to establish if the patient has severe hypoxaemia. The NICE quality standard recommends that such people are referred to a specialist oxygen service for this assessment.

2. Pulmonary rehabilitation

The NICE clinical guideline and quality standard on COPD recommend that people with COPD meeting appropriate criteria are offered an effective, timely and accessible multidisciplinary pulmonary rehabilitation programme.

Pulmonary rehabilitation is defined as a multidisciplinary programme of care for people with chronic respiratory impairment that is individually tailored and designed to optimise each patient's physical and social performance and autonomy.

There is evidence that pulmonary rehabilitation can improve outcomes in people with COPD. NICE recommends that pulmonary rehabilitation should be offered to all patients who consider themselves functionally disabled by COPD (usually MRC dyspnoea grade 3 and above).

For the purpose of the pilot, people on the QOF palliative care register have been excluded from this indicator.

Further information

Further information on COPD can be accessed from the relevant NICE guidance and quality standard on COPD from:

http://guidance.nice.org.uk/CG101

http://www.nice.org.uk/guidance/qualitystandards/chronicobstructivepulmonarydisease/copdqualitystandard.jsp

Indicator area: Heart failure

3. The percentage of patients with heart failure (diagnosed after 1/4/2013) with a record of referral for an exercise based rehabilitation programme

Evidence source

NICE clinical guideline 108: Heart Failure

Recommendation 1.3.1.1: Offer a supervised group exercise-based rehabilitation programme designed for patients with heart failure.

- Ensure the patient is stable and does not have a condition or device that would preclude an exercise-based rehabilitation programme
- Include a psychological and educational component in the programme.
- The programme may be incorporated within an existing cardiac rehabilitation programme.

The conditions and devices that may preclude an exercise-based rehabilitation programme include: uncontrolled ventricular response to atrial fibrillation, uncontrolled hypertension, and high-energy pacing devices set to be activated at rates likely to be achieved during exercise.

NICE Chronic Heart Failure Quality Standard

People with stable chronic heart failure and no precluding condition or device are offered a supervised group exercise-based cardiac rehabilitation programme that includes education and psychological support.

Brief rationale for indicator(s)

Cardiac rehabilitation has been shown to increase physical health and decrease subsequent morbidity and mortality in people with coronary heart disease – specifically in people with chronic heart failure and in those following a myocardial infarction (MI). .

This potential new QOF indicator aims to improve the management of people with heart failure by incentivising referral for an exercise based cardiac rehabilitation programme.

Topic overview

Coronary artery disease (CAD) sometimes referred to as coronary heart disease (CHD), is the narrowing of the arteries to the heart, caused by a build-

up of fatty deposits, which partially restricts and sometimes altogether blocks blood flow to the heart. The blockage of blood flow to the heart causes myocardial infarction, also known as a heart attack, which leads to death of heart muscle. Over time, CAD can weaken the heart muscle and lead to heart failure, whereby the heart is unable to pump enough blood throughout the body.

There are approximately 68,000 new cases of heart failure diagnosed in the UK each year. Heart failure has a poor prognosis with 30-40% of people diagnosed with heart failure dying within a year; thereafter the mortality is less than 10% per year. Heart failure has a major impact on quality of life, and is associated with mood disorders.

Evidence suggests that cardiac rehabilitation could lead to fewer hospital admissions for heart failure. In addition, cardiac rehabilitation has been shown to increase physical health and decrease subsequent morbidity and mortality in people with CHD.

The NICE heart failure Guideline Development Group (GDG) noted that exercise is the most important component of a rehabilitation programme, as education and counselling are usually incorporated into standard care.

The NICE chronic heart failure quality standard also recommends that people with stable chronic heart failure and no precluding condition or device are offered a supervised group exercise-based cardiac rehabilitation programme that includes education and psychological support.

Further information

Further information on heart failure can be accessed from the relevant NICE guidance and quality standard on heart failure and from:

http://guidance.nice.org.uk/CG108

http://www.nice.org.uk/guidance/qualitystandards/chronicheartfailure/home.jsp

Indicator area: Secondary prevention of coronary heart disease (CHD)

Indicators

4. The percentage of patients with an MI within the preceding 15 months with a record of a referral to a cardiac rehabilitation programme

Evidence source

NICE clinical guideline 48: MI secondary prevention

Recommendation 1.2.1.1: All patients (regardless of their age) should be given advice about and offered a cardiac rehabilitation programme with an exercise component

Brief rationale for indicator(s)

Cardiac rehabilitation has been shown to increase physical health and decrease subsequent morbidity and mortality in people with Coronary heart disease – specifically in people following a myocardial infarction (MI) and people with chronic heart failure.

This potential new QOF indicator aims to improve the management of people that have had a MI by incentivising referral to a cardiac rehabilitation programme.

Topic overview

Coronary artery disease (CAD) sometimes referred to as coronary heart disease (CHD), is the narrowing of the arteries to the heart, caused by a build-up of fatty deposits, which partially restricts and sometimes altogether blocks blood flow to the heart. The blockage of blood flow to the heart causes myocardial infarction, also known as a heart attack, which leads to death of heart muscle.

The British Heart Foundation has estimated that there are about 147,000 MIs per year in men of all ages in the UK and 121,000 in women, giving a total of 268,000 cases. In the UK, about 838,000 men and 394,000 women have had an MI.

Evidence suggests that cardiac rehabilitation could potentially lead to a reduction in recurrent myocardial infarctions and subsequent unplanned admissions to secondary care. In addition there is good evidence that comprehensive cardiac rehabilitation as well as exercise-only cardiac rehabilitation reduces cardiac mortality in people post MI.

Further information

Further information on management following a myocardial infarction can be accessed from the relevant NICE guidance from:

http://guidance.nice.org.uk/CG48

Indicator area: Diabetes: Erectile dysfunction

Indicators

5. The percentage of male patients with diabetes with a record of being asked about erectile dysfunction in the preceding 15 months

6. The percentage of male patients with diabetes who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 15 months

Evidence Source

NICE clinical guideline 87: Type 2 diabetes

Recommendation 1.14.4.1: Review the issue of erectile dysfunction with men annually.

Recommendation 1.14.4.2: Provide assessment and education for men with erectile dysfunction to address contributory factors and treatment options.

Recommendation 1.14.4.3: Offer a phosphodiesterase-5 inhibitor (choosing the drug with the lowest acquisition cost), in the absence of contraindications, if erectile dysfunction is a problem.

Recommendation 1.14.4.4: Following discussion, refer to a service offering other medical, surgical, or psychological management of erectile dysfunction if phosphodiesterase-5 inhibitors have been unsuccessful.

NICE clinical guideline 15: Type 1 diabetes

Recommendation 1.11.4.1: Men should be asked annually whether erectile dysfunction is an issue.

Recommendation 1.11.4.2: A PDE5 (phosphodiesterase-5) inhibitor drug, if not contraindicated, should be offered where erectile dysfunction is a problem.

Recommendation 1.11.4.3: Referral to a service offering other medical and surgical management of erectile dysfunction should be discussed where PDE5 inhibitors are not successful.

NICE Diabetes Quality Standard

People with diabetes receive an annual assessment for the risk and presence of the complications of diabetes, and these are managed appropriately.

N.B. A specifically stated complication is sexual dysfunction.

Brief rationale for indicator(s)

Erectile dysfunction (ED) may complicate diabetes in men and can have a significant impact on quality of life.

These two new indicators within the diabetes domain encourage GPs to raise the issue of erectile dysfunction with men in their consultations and to assess and advise about contributory factors and treatment options.

Topic overview

Erectile dysfunction (ED) is a manifestation of autonomic neuropathy as a complication of long-term hyperglycaemia. Erectile dysfunction is a common complication of diabetes. There are large differences in the reported prevalence of ED in men with diabetes, ranging from 35% to 90%. These differences may be attributable to differences in methodology and population characteristics.

The 2009/10 QOF prevalence for the diabetes register is 5.4% for England, 4.1% for Scotland, 4.9% for Wales and 3.9% for Northern Ireland. Based on several assumptions, it can be estimated that the prevalence of men with diabetes who experience ED within the total England GP registered practice population for persons aged 18 years and over is 1.69%, or 1.33% for all ages. This equates to a notional figure of 138 men with diabetes who may experience ED for an average registered GP list of 10,000 people (children and adults).

There is evidence that interventions for ED improve quality of life. ED is also considered to be a cardiovascular risk factor conferring a risk equivalent to a moderate level of smoking. Risk factors for ED include sedentary lifestyle, obesity, smoking, hypercholesterolaemia and the metabolic syndrome.

Treatment options include the use of phosphodiesterase type 5 (PDE-5) inhibitors (which can be prescribed and issued on the NHS for men aged over 18 with diabetes) or referral as appropriate to a service with other medical, surgical, or psychological services for the management of erectile dysfunction.

Further information

Further information on diabetes can be accessed from the relevant NICE guidance on diabetes from:

http://guidance.nice.org.uk/CG15

http://guidance.nice.org.uk/CG66

http://guidance.nice.org.uk/CG87

Indicator area: Depression

Indicators

7. The percentage of patients with depression who have had a bio-psychosocial assessment by the point of diagnosis

8. The percentage of patients with a new diagnosis of depression (in the preceding 1 April to 31 March) who have been reviewed within 10-35 days of the date of diagnosis

Evidence source

NICE clinical guideline 90: Depression in adults

Recommendation 1.3.1.1: Be alert to possible depression (particularly in people with a past history of depression or a chronic physical health problem with associated functional impairment) and consider asking people who may have depression two questions, specifically:

- During the last month, have you often been bothered by feeling down, depressed or hopeless?
- During the last month, have you often been bothered by having little interest or pleasure in doing things?

Recommendation 1.3.1.3: If a person answers 'yes' to either of the depression identification questions (see 1.3.1.1), a practitioner who is competent to perform a mental health assessment should review the person's mental state and associated functional, interpersonal and social difficulties.

Recommendation 1.4.1.3: For people who, in the judgement of the practitioner, may recover with no formal intervention, or people with mild depression who do not want an intervention, or people with subthreshold depressive symptoms who request an intervention:

- discuss the presenting problem(s) and any concerns that the person may have about them
- provide information about the nature and course of depression
- arrange a further assessment, normally within 2 weeks
- make contact if the person does not attend follow-up appointments.

Recommendation 1.5.2.6: For people started on antidepressants who are not considered to be at increased risk of suicide, normally see them after 2

weeks. See them regularly thereafter for example, at intervals of 2 to 4 weeks in the first 3 months, and then at longer intervals if response is good.

Recommendation 1.4.1.3: For people who, in the judgement of the practitioner, may recover with no formal intervention, or people with mild depression who do not want an intervention, or people with subthreshold depressive symptoms who request an intervention:

- discuss the presenting problem(s) and any concerns that the person may have about them
- provide information about the nature and course of depression
- arrange a further assessment, normally within 2 weeks
- make contact if the person does not attend follow-up appointments.

NICE Quality Standard Depression

People who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode.

Brief rationale for indicator(s)

These two potential new QOF indicators for depression have been developed with the intention to replace the current QOF indicators DEP 4 and DEP 5.

The first potential new QOF indicator aims to encourage a holistic (bio-psychosocial) assessment of people with depression and record this at the point a formal diagnosis of depression is entered into the patient's notes.

The second indicator encourages timely follow-up of all people with depression and for the following to be reviewed:

- side effects and efficacy of medication
- depression symptoms
- social support
- other treatment options
- progress of other referrals
- suicidal ideation (as appropriate)
- To reinforce messages about duration of medication because early cessation of treatment is associated with a greater risk of relapse.

Topic Overview

Major depressive disorder is common and is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for

people, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs.

1. ***Biopsychosocial assessment***

The NICE clinical guidelines on depression highlight the need for a holistic approach to the assessment and management of depression. The diagnostic process for depression should involve the primary health care practitioner conducting a biopsychosocial assessment that considers the person's mental state and associated functional, interpersonal and social difficulties.

2. ***Review***

The NICE clinical guideline on depression recommends that people started on antidepressants who are not at increased risk of suicide, are seen after 2 weeks and at regular intervals thereafter e.g. 2-4 weeks.

NICE also recommends a further assessment, normally within 2 weeks, in those people who, in the judgement of the practitioner, may recover with no formal intervention, or people with mild depression who do not want an intervention.

The second potential new indicator for depression more closely reflects the NICE guidance whilst supporting practices to provide continuity of care by allowing some flexibility for appointment availability.

Further information

Further information on depression can be accessed from the relevant NICE guidance and quality standard on depression from:

http://guidance.nice.org.uk/CG90

http://guidance.nice.org.uk/CG91

http://www.nice.org.uk/guidance/qualitystandards/depressioninadults/home.jsp

Indicator area: Diabetes: Lipid management

Indicator

9. The percentage of patients with Type 2 diabetes aged 40 years and over with successful lipid management defined as either:

    1. last recorded cholesterol in the preceding 12 months ≤ 4.0mmol/l

    2. last recorded cholesterol in the preceding 12 months > 4.0mmol/l and commenced on a moderate dose generic statin within 90 days of cholesterol recording

    3. last recorded cholesterol in the preceding 12 months > 4.0mmol/l and generic statin dose increased within 90 days of cholesterol recording

    4. or, last recorded cholesterol in the preceding 12 months > 4.0mmol/l and cholesterol lowering therapy changed to a different drug within 90 days of cholesterol recording

Evidence source

NICE clinical guideline 66: Type 2 diabetes: the management of type 2 diabetes

Recommendation 1.10.1.1: Review cardiovascular risk status annually by assessment of cardiovascular risk factors, including features of the metabolic syndrome and waist circumference, and change in personal or family cardiovascular history.

Recommendation 1.9.4: Perform a full lipid profile (including high-density lipoprotein [HDL] cholesterol and triglyceride estimations) when assessing cardiovascular risk after diagnosis and annually, and before starting lipid-modifying therapy.

Recommendation 1.10.1.2: For a person who is over 40 years old or over:

- Initiate therapy with generic simvastatin (to 40 mg) or a statin of similar efficacy and cost unless the cardiovascular risk from non-hyperglycaemia-related factors is low
- If the cardiovascular risk from non-hyperglycaemia-related factors is low, assess cardiovascular risk using the UKPDS risk engine and initiate simvastatin therapy (to 40 mg), or a statin of similar efficacy and cost, if the cardiovascular risk exceeds 20% over 10 years

Recommendation 1.10.1.4: Once a person has been started on cholesterol lowering therapy, assess his or her lipid profile (together with other modifiable risk factors and any new diagnosis of cardiovascular disease) 1-3 months after starting treatment, and annually thereafter. In those not on cholesterol lowering therapy, reassess cardiovascular risk annually, and consider initiating a statin

Recommendation 1.10.1.5: Increase the dose of simvastatin, in anyone initiated on simvastatin in line with the above recommendations, to 80 mg daily unless total cholesterol level is below 4.0 mmol/litre or low-density lipoprotein [LDL] cholesterol level is below 2.0 mmol/litre.

Recommendation 1.10.1.6: Consider intensifying cholesterol-lowering therapy (with a more effective statin or ezetimibe in line with NICE guidance)13 if there is existing or newly diagnosed cardiovascular disease, or if there is an increased albumin excretion rate, to achieve a total cholesterol level below 4.0 mmol/litre (and HDL cholesterol not exceeding 1.4 mmol/litre) or an LDL cholesterol level below 2.0 mmol/litre

NICE Diabetes Quality Standard

People with diabetes agree with their healthcare professional to start, review and stop medications to lower blood glucose, blood pressure and blood lipids in accordance with NICE guidance.

Brief rationale for indicator(s)

People with type 2 diabetes aged over 40 are at high risk of cardiovascular disease and are likely to require lipid-lowering therapy. Assessment and management will require monitoring of total cholesterol level and initiation of statin therapy.

These indicators are intended to incentivise both the initiation of statin therapy and monitoring of total cholesterol levels to ensure that statin dose is adjusted as appropriate.

These indicators are termed “tightly linked measures” as they combine a process measure that is strongly linked to improved health outcomes (statin therapy) with the use of an intermediate outcome measure (total cholesterol levels) and specify what treatment actions need to happen as a result of a raised total cholesterol level. This potential new QOF indicator aims to test out the feasibility of implementing and extracting data on a tightly linked measure for diabetes lipid management for UK QOF.

Topic Overview

Lipid management

Nearly all people with Type 2 diabetes are at high cardiovascular risk. Statins are a well established therapy to reduce cholesterol for the prevention of cardiovascular events. The current QOF indicator for diabetes cholesterol management, DM17, uses an audit standard to incentivise statin therapy to reduce cholesterol in people whose total cholesterol is greater than 5.0mmol/l. The NICE type 2 diabetes guideline, however, recommends that all people with diabetes aged over 40 should be initiated on statin therapy to prevent CVD (except if they have no established CVD and their 10 year CVD risk using a diabetes specific risk score – UKPDS - is assessed as less than 20%) and that treatment intensification (increasing the dose of statins) should be actioned unless the total cholesterol is less than 4.0 mmol/l.

Tightly linked measures

Literature shows that simple measures such as the proportion of people in control of their condition (e.g. diabetes) can underestimate the proportions receiving high quality clinical care and suggests that more sophisticated measures e.g. treatment intensification, could improve quality assessment.

Evidence suggests that measurement and feedback of the frequency with which pharmacotherapy is intensified in people with poorly controlled risk factors may represent a useful approach to clinical quality measurement and improvement. Studies have also found that treatment intensification is tightly linked to improved control.

Tightly linked measures specify processes that are strongly associated with important outcomes, and intrinsically take the severity of disease into account and identify appropriate quality improvement responses. The measures are considered to be “tightly linked” because the link between processes and outcomes, and between measures and potential quality improvement responses is considered to be more clearly established.

Tightly linked measures may reduce the risks of overtreatment and adverse consequences from excessive focus on tight risk factor targets. For this tightly linked measure, a value of 4.0mmol/l of total cholesterol is considered an appropriate threshold for measuring intervention and is in line with the NICE guidance on type 2 diabetes.

Further information

Further information on diabetes can be accessed from the relevant NICE guidance and quality standard on diabetes from:

http://guidance.nice.org.uk/CG15

http://guidance.nice.org.uk/CG66

http://guidance.nice.org.uk/CG87

http://www.nice.org.uk/guidance/qualitystandards/diabetesinadults/diabetesinadultsqualitystandard.jsp

Indicator area: Hypertension

Indicator

10. The percentage of patients under 80 years old with hypertension in whom the last recorded blood pressure (measured in the preceding 9 months) is 140/90 or less

11. The percentage of patients aged 80 years and over with hypertension in whom the last recorded blood pressure (measured in the preceding 9 months) is 150/90 or less

Evidence source

NICE clinical guideline 127: Hypertension: management of hypertension in adults in primary care

Recommendation: 1.5.5: Aim for a target clinic blood pressure below 140/90 mmHg in people aged under 80 years with treated hypertension

Recommendation 1.5.6: Aim for a target clinic blood pressure below 150/90 mmHg in people aged 80 years and over, with treated hypertension.

Brief rationale for indicator(s)

The current QOF hypertension blood pressure control indicator uses an audit standard of 150/90 or less.

These two potential new QOF indicators aim to test out the feasibility of introducing tighter blood pressure targets into UK QOF and the feasibility of introducing blood pressure targets into UK QOF for people over the age of 80 years, in line with current NICE guideline 127 on hypertension.

Topic Overview

There is evidence that in people aged under 80 years with hypertension on treatment a higher achieved blood pressure is associated with a higher risk of cardiovascular events that a blood pressure on treatment of <140/90mmHg is associated with a lower risk of cardiovascular events. The NICE hypertension guideline therefore recommends that the target blood pressure for people aged under 80 treated for hypertension should be <140/90 mmHg (consistent with the usual target blood pressure in clinical outcome trials), based on clinic blood pressure readings.

For people aged over 80 years the evidence supports a higher systolic BP target. The NICE hypertension guideline therefore recommends that the target blood pressure for people aged 80 years and over is 150/90 based on clinic BP readings. The key studies supporting this recommendation generally

included older people who were fit and active and had low levels of comorbidities. It is therefore noted in the guideline that treatment decisions in those aged ≥80 years should be based on the realistic expectations of clinical benefit from treatment in the context of other comorbidities which might limit life expectancy.

Further information

Further information on hypertension can be accessed from the relevant NICE guidance from:

http://guidance.nice.org.uk/CG127

Indicator area: Rheumatoid arthritis

Indicators

12. The practice can produce a register of all patients aged 16 years and over with rheumatoid arthritis

13. The percentage of patients with rheumatoid arthritis in whom CRP or ESR has been recorded at least once in the preceding 15 months

14. The percentage of patients with rheumatoid arthritis aged 30-84 years who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 15 months

15. The percentage of patients with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA

16. The percentage of patients with rheumatoid arthritis who have had a face to face annual review in the preceding 15 months

Evidence source

NICE clinical guideline 79: Rheumatoid arthritis: the management of rheumatoid arthritis in adults

Recommendation 1.5.1.1: Measure CRP and key components of disease activity (using a composite score such as DAS28) regularly in people with RA to inform decision-making about:

- increasing treatment to control disease
- cautiously decreasing treatment when disease is controlled

Recommendation 1.5.1.4: Offer people with RA an annual review to:

- assess disease activity and damage, and measure functional ability (using, for example, the Health Assessment Questionnaire [HAQ])
- check for the development of comorbidities, such as hypertension, ischaemic heart disease, osteoporosis and depression
- assess symptoms that suggest complications, such as vasculitis and disease of the cervical spine, lung or eyes
- organise appropriate cross referral within the multidisciplinary team
- assess the need for referral for surgery (see section 1.6)
- assess the effect the disease is having on a person's life

Brief rationale for indicator(s)

These five indicators aim to explore the feasibility of creating a new QOF register of people over the age of 16 who have rheumatoid arthritis (RA). Indicators one to four aim to promote review of cases of RA in primary care through promoting assessment of inflammatory markers (CRP or ESR) and introducing a specific cardiovascular and fracture risk assessment for people with RA. The fifth indicator aims to test the feasibility of opportunistically undertaking a specific annual review in people with RA.

Topic overview

Rheumatoid arthritis (RA) is a chronic and progressive disabling condition characterised by inflammation of the synovial tissue of the joints, typically affects the small joints of the hands and the feet. Ongoing inflammation and loss of mobility can result in a range of co-morbidities, including the development of cardiovascular disease, infection and osteoporosis.

The National Audit Office provides an estimated adult prevalence (ages 15+) of 1.4% for England. RA affects three times as many women as men and has a peak age of onset of 40–70 years.

The course of RA is heterogeneous and variable. However, a number of factors have been identified as being associated with poor prognosis. These include the presence of rheumatoid factor antibodies, high erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) levels, early radiographic evidence of erosions and the presence of swollen and tender joints.

Treatment aims to control pain and inflammation, and to reduce joint damage, disability and loss of function, thereby improving quality of life. It involves a combination of pharmacological and non-pharmacological interventions. Conventional drug therapy relies on various combinations of non-steroidal anti-inflammatory drugs (NSAIDs), analgesics, corticosteroids and Disease-modifying Anti-rheumatic Drugs (DMARDs).

For people with confirmed RA there is a need for regular assessment to determine disease status, assess severity, monitor the efficacy and toxicity of drug therapy, and promptly identify any co-morbidities or complications associated with RA. In particular, people with RA are at increased risk of osteoporosis and CVD and it is important that their risk of these conditions is formally assessed. People with satisfactorily controlled established RA require review appointments for ongoing drug monitoring, additional visits for disease flares and rapid access to specialist care.

Further information

Further information on rheumatoid arthritis can be accessed from the relevant NICE guidance from:

http://guidance.nice.org.uk/CG79

Indicator area: Asthma

Indicators

17. The percentage of patients, 5 years and over, newly diagnosed as having asthma from 1 April 2013 in whom there is a record that the diagnosis of asthma has been made supported by the current BTS-SIGN guidelines

18. The percentage of children reaching the age of 5 years after or on 1 April 2013 with an existing diagnosis of asthma in whom there is a record that the diagnosis of asthma has been reviewed and confirmed (supported by the current BTS-SIGN guidelines) within 15 months of becoming 5 years

Evidence source

SIGN guideline 101: British Guideline on the Management of Asthma

Diagnosis in children: Focus the initial assessment in children suspected of having asthma on:

- presence of key features in the history and examination
- careful consideration of alternative diagnoses.

Based on the initial clinical assessment it should be possible to determine the probability of a diagnosis of asthma with a thorough history and examination, an individual child can usually be classed into one of three groups

- **high probability** – diagnosis of asthma likely
- **low probability** – diagnosis other than asthma like
- **intermediate probability** – diagnosis uncertain

Diagnosis in adults:

As with children there is a need to assess the probability of asthma in terms of high, low or intermediate.

Base initial diagnosis on a careful assessment of symptoms and a measure of airflow obstruction:

- in patients with a high probability of asthma move straight to a trial of treatment. Reserve further testing for those whose response to a trial of treatment is poor.
- in patients with a low probability of asthma, whose symptoms are thought to be due to an alternative diagnosis, investigate and manage accordingly. Reconsider the diagnosis of asthma in those who do not respond.

- the preferred approach in patients with an intermediate probability of having asthma is to carry out further investigations, including an explicit trial of treatments for a specified period, before confirming a diagnosis and establishing maintenance treatment.

Brief rationale for indicator(s)

Both indicators intend to amend the current QOF indicator Asthma 8 to conform to the updated British BTS-SIGN guidelines on the management of asthma. The age range has also been reduced from 8 years to 5 years in line with current evidence. The first indicator allows practitioners to record asthma at the point where they are still deciding if the patient has asthma, allowing a period of time for the confirmation of diagnosis. This aims to improve the quality of diagnosis by prompting healthcare practitioners to consider the variety of information sources available to them and to document in the patient's notes the basis for arriving at a diagnosis.

The second indicator encourages the primary care team to review any diagnosis of asthma made before the age of five to ensure that children are not incorrectly labelled with the condition and that those with asthma continue to be treated appropriately.

Topic overview

The diagnosis of asthma is based on recognising a characteristic pattern of symptoms and signs and the absence of an alternative explanation for them.

In some children, and particularly those below the age of four to five, there is insufficient evidence at the first consultation to make a firm diagnosis of asthma, but no features to suggest an alternative diagnosis. At above five years of age, conventional lung function testing is possible in most children in most settings. This includes measures of airway obstruction (spirometry and peak flow), reversibility with bronchodilators, and airway hyper-responsiveness.

It is important that assessment of a child with suspected asthma follows the advice set out in the BTS-SIGN asthma guideline as misdiagnosis commonly occurs.

Further information

Further information on asthma can be accessed from the relevant SIGN guidance from:

http://www.sign.ac.uk/guidelines/fulltext/101/index.html

Indicator area: Cancer

Indicators

19. The percentage of patients with cancer diagnosed within the preceding 18 months who have a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis

20. The percentage of patients with recurrent or distant metastatic cancer diagnosed within the preceding 18 months who have a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis

Evidence source

This is a revision of existing QOF indicators developed under the previous (pre-NICE) expert panel process and as such cannot easily be mapped against NICE or SIGN clinical guideline recommendations.

Brief rationale for indicator(s)

These two potential new QOF indicators intend to amend the current QOF indicator Cancer 3 by decreasing the timeframe for review following confirmation of diagnosis from 6 months to 3 months, and extending the cancer review to include people with new and metastatic cancer.

Over the last 20 years average lengths of stay post-treatment for most cancers have been declining, and evidence suggests that people quickly resume consultations in general practice. Expert advice also suggests that there are few fundamental differences between new, and metastatic cancer in terms of initial primary care management. These indicators therefore aim to build a formal 3 month cancer review into cancer consultations and encourage early involvement and review for people with recurrent or distant metastatic cancer.

Topic overview

The number of people successfully treated for cancer is increasing and this has led to an increase in the number of people requiring follow up care, monitoring and management. In addition, there is good evidence that the period around diagnosis is critical and that people with newly diagnosed cancer have a lower quality of life than those with longer term cancer.

Cancer experts consider that a diagnosis of metastatic cancer has no lesser psychosocial impact than the primary diagnosis. In addition, there is evidence

that people with metastatic cancer have particular acute information needs in the immediate post diagnostic period.

The Cancer Reform Strategy (Department of Health, 2007) highlighted the need to conduct a full assessment of an individual patient's needs at key stages in the care pathway including at diagnosis, at the end of treatment and when a relapse occurs.

Early face to face review with patients with new primary or new metastatic cancer is considered by experts to be the most likely method for identifying physical and psychosocial needs requiring management and subsequent monitoring

Appendix B: Consultation proforma

Potential new indicators for QOF

Consultation dates: 9th January 2012 – 6th February 2012

General Comments

Stakeholders are welcomed to submit comments in **Table 1** for all indicators based on the following set of questions:

5. Do you think there are any barriers to the implementation of the care described by any of these indicators?

6. Do you think there are potential unintended consequences to the implementation of any of these indicators?

7. Do you think there is potential for differential impact (in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation), if so please state whether this is adverse or positive and for which group?

8. If you think any of these indicators may have an adverse impact in different groups in the community, can you suggest any guidance on adaptation to the delivery of the indicator to different groups which might reduce health inequalities?

Specific Questions

There are a number of specific question we would like to ask on certain indicators. These are outlined in **Table 2** of the comments proforma

How to submit your comments

If you would like to comment on any of the 20 indicators currently being consulted on please use the comments proforma and forward this to Emma Boileau at qof@nice.org.uk.

Comments proforma

Consultee name:		Consultee organisation:	

Table 1: Stakeholder comments on all indicators

Indicator Area	Indicator	Consultee comments
COPD	1. The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the preceding 15 months	
COPD	2. The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of a referral to a pulmonary rehabilitation programme (excluding patients on the palliative care register)	
Heart Failure	3. The percentage of patients with heart failure (diagnosed after 1/4/2013) with a record of referral for an exercise based rehabilitation programme	
Secondary prevention of CHD	4. The percentage of patients with an MI within the preceding 15 months with a record of a referral to a cardiac rehabilitation programme	
Diabetes	5. The percentage of male patients with diabetes with a record of being asked about erectile dysfunction in the preceding 15 months	

Indicator Area	Indicator	Consultee comments
Diabetes	6. The percentage of male patients with diabetes who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 15 months	
Depression	7. The percentage of patients with depression who have had a bio-psychosocial assessment by the point of diagnosis	
Depression	8. The percentage of patients with a new diagnosis of depression (in the preceding 1 April to 31 March) who have been reviewed within 10-35 days of the date of diagnosis	

Indicator Area	Indicator	Consultee comments
Diabetes: Lipid management	9. The percentage of patients with Type 2 diabetes aged 40 years and over with successful lipid management defined as either: 1. last recorded cholesterol in the preceding 12 months ≤ 4.0mmol/l 2. last recorded cholesterol in the preceding 12 months > 4.0mmol/l and commenced on a moderate dose generic statin within 90 days of cholesterol recording 3. last recorded cholesterol in the preceding 12 months > 4.0mmol/l and generic statin dose increased within 90 days of cholesterol recording 4. or, last recorded cholesterol in the preceding 12 months > 4.0mmol/l and cholesterol lowering therapy changed to a different drug within 90 days of cholesterol recording	
Hypertension: Blood pressure management	10. The percentage of patients under 80 years old with hypertension in whom the last recorded blood pressure (measured in the preceding 9 months) is 140/90 or less	
Hypertension	11. The percentage of patients aged 80 years and over with hypertension in whom the last recorded blood pressure (measured in the preceding 9 months) is 150/90 or less	
Rheumatoid arthritis	12. The practice can produce a register of all patients aged 16 years and over with rheumatoid arthritis	

Indicator Area	Indicator	Consultee comments
Rheumatoid arthritis	13. The percentage of patients with rheumatoid arthritis in whom CRP or ESR has been recorded at least once in the preceding 15 months	
Rheumatoid arthritis	14. The percentage of patients with rheumatoid arthritis aged 30-84 years who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 15 months	
Rheumatoid arthritis	15. The percentage of patients with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA	
Rheumatoid arthritis	16. The percentage of patients with rheumatoid arthritis who have had a face to face annual review in the preceding 15 months	
Asthma	17. The percentage of patients, 5 years and over, newly diagnosed as having asthma from 1 April 2013 in whom there is a record that the diagnosis of asthma has been made supported by the current BTS-SIGN guidelines	
Asthma	18. The percentage of children reaching the age of 5 years after or on 1 April 2013 with an existing diagnosis of asthma in whom there is a record that the diagnosis of asthma has been reviewed and confirmed (supported by the current BTS-SIGN guidelines) within 15 months of becoming 5 years	

Indicator Area	Indicator	Consultee comments
Cancer	19. The percentage of patients with cancer diagnosed within the preceding 18 months who have a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis	
Cancer	20. The percentage of patients with recurrent or distant metastatic cancer diagnosed within the preceding 18 months who have a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis	

Table 2: Stakeholder specific comments on certain indicators

Indicator Area	Indicator	Consultee comments
COPD	**Indicator 2: The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of a referral to a pulmonary rehabilitation programme (excluding patients on the palliative care register)** For the purpose of the pilot, people on the QOF palliative care register have been excluded from this indicator: 1. Do stakeholders consider it appropriate to exclude people on the palliative care register from this indicator?	
CHD & Heart Failure	**Indicators 3and 4: The percentage of patients with heart failure (diagnosed after 1/4/2013) with a record of referral for an exercise based rehabilitation programme AND The percentage of patients with an MI within the preceding 15 months with a record of a referral to a cardiac rehabilitation programme** 2. If someone with an MI that has been referred for cardiac rehabilitation subsequently develops heart failure, should they: a) Still be referred to an exercise based rehabilitation programme? b) Be excluded from the indicator and not referred to an exercise based rehabilitation	

Indicator Area	Indicator	Consultee comments
	programme	
Depression	**Indicator 8: The percentage of patients with a new diagnosis of depression (in the preceding 1 April to 31 March) who have been reviewed within 10-35 days of the date of diagnosis** A time frame of 10-35 days has been chosen for piloting based on the NICE recommendations for review and to allow flexibility around the setting of appointments. 3. Do stakeholders consider the timeframe outlined in the indicator appropriate? 4. If the timeframe stipulated is **not** considered to be appropriate could you suggest and alternative timeframe?	
Rheumatoid arthritis	**Indicator 12: The practice can produce a register of all patients aged 16 years and over with rheumatoid arthritis** For the purpose of the pilot, an age range of 16 has been chosen for the RA register because at this age a person is unlikely to have a juvenile RA: Is this the appropriate age range to include in this indicator set? 5. If no, is there an alternative age range that should be applied to the indicator?	

Indicator Area	Indicator	Consultee comments
Rheumatoid arthritis	**Indicator 14: The percentage of patients with rheumatoid arthritis aged 30-84 years who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 15 months** The timeframe of '15 months', has been included in this indicator for the purposes of piloting: 14. What timeframe should be included in the indicator for an assessment of CVD risk?	
Rheumatoid arthritis	**Indicator 15: The percentage of patients with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA** The timeframe for this indicator is under review: 15. What timeframe (if any) should be included in the indicator for an assessment of fracture risk?	